



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

APPLICATION FOR PERSONAL ASSISTANCE SERVICES AGENCY LICENSE

AGENCY NAME

Print

AGENCY ADDRESS

ADDRESS 1

ADDRESS 2

CITY

STATE

ZIP CODE

DIRECTOR

Print

OTHER CONTACT

AS APPROPRIATE

Print

PHONE NUMBERS

AGENCY PHONE NUMBER

AGENCY FAX NUMBER

EMAIL ADDRESS

AGENCY TYPE

☐

PRIVATE

☐

NOT FOR PROFIT

PLEASE CHECK ALL THAT APPLY

☐

PUBLIC

☐

PROPRIETARY

OFFICE HOURS: _____

☐

EMPLOYEES ONLY

☐

CONTRACTORS ONLY

☐

EMPLOYEES AND CONTRACTORS

GEOGRAPHIC AREA SERVED:

Print

SERVICES PROVIDED:

☐

ADLS

☐

LIVE IN

☐

COMPANIONSHIP

☐

HOMEMAKER

☐

TRANSPORTATION

☐

LICENSED HOME HEALTH

☐

OTHER (PLEASE LIST)

PLEASE ATTACH THE MOST CURRENT COPY OF THE FOLLOWING:

1. A LIST SHOWING THE NAMES AND ADDRESSES OF EACH OFFICER, DIRECTOR, AND OWNER HAVING FIVE (5) PERCENT OR MORE INTEREST IN THE AGENCY.
2. A LIST SHOWING THE NAMES AND ADDRESSES OF THE GOVERNING BODY, IF DIFFERENT FROM THE PRECEDING GROUP.
3. HOME HEALTH AGENCY LICENSE (IF DUALY LICENSED)
4. OTHER: _____

NAME OF PERSON COMPLETING THIS FORM: _____

Print

SIGNATURE: _____

TITLE: _____

DATE: _____

CHECKS SHOULD BE MADE PAYABLE TO: **DELAWARE DIVISION OF PUBLIC HEALTH**

INITIAL APPLICATION FEE:

\$250.00 ☐

ANNUAL LICENSURE FEE:

\$100.00 ☐

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE AND ATTACHMENTS TO
OFFICE OF HEALTH FACILITIES LICENSING & CERTIFICATION
2055 LIMESTONE ROAD
SUITE 200
WILMINGTON DE 19808

05/07

Doc. No. # 35-05-20/08/02/56